INITIAL PAIN EVALUATION FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ FAMILY DOCTOR _____

NAME_____ DATE OF BIRTH ____ /____ /____

SOCIAL SECURITY #_____

CHIEF COMPLAINT - What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

Were you referred to us by another health care professional? (If yes please state name)_____

HPI:

Height: _____ Weight: _____

My current Problem is the result of a (check all that apply):

☐ Car Accident

☐ Work Injury

☐ Legal Case

☐ Other _____

When did the problem first start? _____

Date, if accident or work injury _____Has a workers' compensation claim been filed? ☐ Yes ☐ No

Have you seen other physicians for this problem? ☐ Yes ☐ No
If so, who? _____

What treatments have you had for **this problem**?

☐ Physical Therapy (check all that apply)

☐ Injections

☐ Chiropractic

☐ Surgery

☐ TENS

Location of the problem: (check all that apply)

☐ Low Back

☐ Buttock (Right Left Both)

☐ Leg (Right Left Both)

☐ Neck

☐ Arm (Right Left Both)

Severity: ☐ Mild ☐ Moderate ☐ Severe

What activities make it better?

☐ Rest

☐ Stretching

☐ Ice

☐ Heat

What activities make it worse?

☐ Walking

☐ Sitting

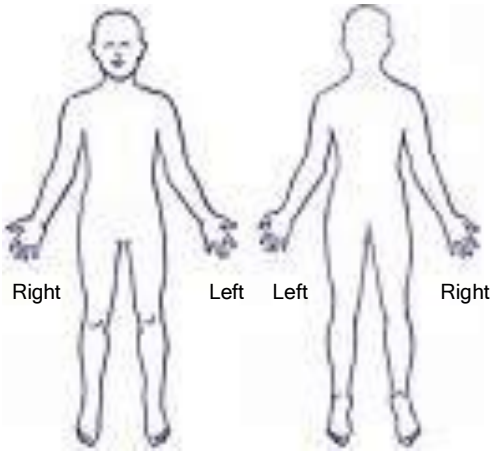
☐ Standing

☐ Lying Down

☐ Riding / Driving

☐ Coughing / Sneezing

Please draw area of pain. If the pain radiates, describe this as well:



FRONT BACK

Please mark all that apply to you now or that you have had in the past!

Eyes	Y	N	**Genitourinary**	Y	N	**Endocrine**	Y	N
Glaucoma			Can't control urine			Diabetes		
			Difficulty urinating					
HENT	Y	N				**Psychiatric**	Y	N
Wearing hearing aide			**Integumentary**	Y	N	Anxiety		
			Skin Cancer			Depression		
Cardiovascular	Y	N						
Chest pain/angina			**Neurological**	Y	N	**Hematological**	Y	N
Leg pain while walking			Sciatica			Bleeding Tendencies		
Pacemaker			Arm Numbness/ Tingling			DVT		
			Leg Numbness/ Tingling					
Respiratory	Y	N				**Allergic**	Y	N
Asthma/Emphysema			**Musculoskeletal**	Y	N	Food allergies		
			Neck Pain			Medication allergies		
Gastrointestinal	Y	N	Arm Pain			Iodine allergy		
Blood in vomit			Back Pain					
Colon cancer			Leg/ Foot Pain			**Female**	Y	N
						Are you pregnant?		
						Unsure?		

PAST MEDICAL HISTORY:

List all chronic illnesses/conditions: (Example: diabetes, heart disease, high blood pressure, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

List any past surgeries

Surgery Approximate Date

_____
_____
_____
_____
_____
_____

Are you on any medications? Y N (If yes, list all or provide a list)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any medication allergies? ☐ Yes ☐ No (If yes, list all or provide a list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No
If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much? _____

Occupation/Employer: _____

Have you had any complications with bleeding? ☐ Yes ☐ No

Do you take a blood thinner, such as Coumadin, Plavix, Heparin, Aspirin, etc?
If so, what? _____

Family History:	*Serious Health Problems / Important* Notes:
Mother If deceased, at what age? _____	
Father If deceased, at what age? _____	

The information given in the Patient History form is accurate to the best of my knowledge.

Signature_____ Date _____